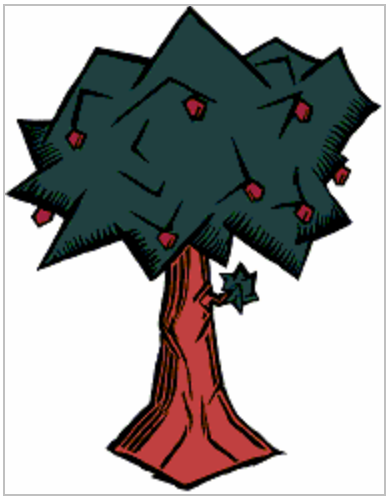
State of Washington

Department of Social and Health Services



MMIS Business and System Requirements Analysis Project

ACES Interface Assessment Report

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Revision History

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1. Executive Summary

1.1 Project Overview

The Washington MMIS Business and System Requirements Analysis project is the first step in the Medicaid Management Information System (MMIS) re-procurement process. The Department of Social and Health Services (DSHS) and FourThought Group will work together to discover, analyze, and document the state's current and future Medicaid business practices and system needs. At the highest level, the scope of this project is defined by the following project objectives:

- Document the current technological and organizational environment.
- Identify high-level issues with the current MMIS and the high-level needs for the future system.
- Identify the functional system requirements for the future MMIS.
- Analyze alternatives and recommend a future technological infrastructure development strategy.
- Analyze alternatives and recommend a future MMIS procurement strategy.
- Analyze the current state of the Medicaid Medical Eligibility Determination process in DSHS and recommend a future direction for that process.
- Perform a Business Process Review (BPR) for four functional areas of the Medicaid program: MMIS services, Claims Processing and Adjudication, Prior Authorization, and Provider Enrollment.

DSHS has the option of extending the project to include two additional objectives:

- Development of an Advanced Planning Document (APD).
- Development of a Request for Proposal (RFP) for the selected procurement option.

These objectives were derived from the project requirements specified in the Request for Proposal (RFP) developed by DSHS and the proposal submitted by FourThought Group in response to the RFP. Some objectives were derived from additional service contracts awarded after the initial contract. Fulfilling the objectives of this project will establish the basis by which the state can make sound Medicaid technology investments in the future.

1.2 Introduction

This deliverable is a stand-alone report that summarizes the issues and needs of both the Medical Assistance Administration (MAA) and the Economic Services Administration (ESA), focusing on an evaluation of moving Medicaid eligibility determination from ESA to MAA. The report is an analysis of the current state of the Medicaid Medical Eligibility Determination process in DSHS and a recommendation for future direction of this process.

1.2.1 Scope

This ACES Interface Assessment Report included a review of the eligibility intake and determination business process. FourThought Group (4TG) identified and interviewed the staff members from ESA who work with the Automated Client Eligibility System (ACES) and are responsible for the Medicaid eligibility determination process. 4TG also identified and interviewed MAA staff members who are responsible for working with the eligibility interface between ACES and the MMIS. To ensure a comprehensive look at the issues, 4TG also interviewed staff members from the Aging and Disability Services Administration (ADSA), the Children's Administration (CA), and the Health and Rehabilitative Services Administration (HRSA). 4TG utilized the Client Requirements Joint Application Development (JAD) session held in December 2003 as a focus group session where members from both ESA and MAA reviewed their issues and needs.

4TG independently researched how other state Medicaid agencies handle eligibility determination.

As part of this ACES Interface Assessment Report, 4TG reviewed the interface between the MMIS and ACES. Out of this review 4TG documented the identified needs and issues and made recommendations for improving the interface process.

Based on the JAD sessions, interviews with ESA and MAA staff, insight and knowledge gained from how other state Medicaid agencies handle eligibility determination, and a review of the ACES eligibility interface, 4TG has reported their findings, identified issues and made recommendations regarding the future direction of Medicaid eligibility determination for DSHS.

The scope of this report did not include any requirements definition nor did it include any modifications to the MMIS System Requirements deliverable. 4TG offers to make a formal presentation to DSHS leadership that summarizes the issues, findings, and recommendations from this report.

1.2.2 Approach

This report was assembled utilizing documentation from the JAD sessions, interviews with DSHS staff, insight and knowledge gained from how other state Medicaid agencies handle eligibility determination, and a review of the ACES eligibility interface.

1.2.3 Document Overview

This document breaks down the needs and issues related to Medicaid Eligibility Determination as well as identifying opportunities and making a recommendation to DSHS regarding the direction for Medicaid Eligibility Determination with the new MMIS.

There are two appendix sections included: a glossary and references.

2. Needs and Issues

2.1 Background

The Washington Department of Social and Health Services (DSHS) consists of the following administrations:

- Executive Administration (EA)
  - The Executive Offices of the Secretary and Deputy Secretary provide comprehensive core services, information and assistance to the public, the department, the legislature, the governor and federal, state, local, tribal and non-profit entities.
- Aging and Disability Services Administration (ADSA)
  - ADSA brings together the major long-term care programs (home care, residential care, boarding homes, adult family homes, and nursing homes) targeted to adults and seniors with disabilities.
- Children's Administration (CA)
  - CA is committed to the safe and healthy growth and development of children in their own homes, in out-of-home placement and in child day care. CA provides a comprehensive range of services to protect children from abuse and neglect, to support families, and to assure quality care for children.
- Economic Services Administration (ESA)
  - ESA provides financial assistance and related support services to help people in need achieve and maintain their highest level of self-sufficiency.
- Health & Rehabilitative Services Administration (HRSA)
  - Serves Washington citizens often characterized as those most profoundly in need. HRSA clients have needs arising from physical and mental disabilities, mental health problems or chemical abuse or dependency problems.
- Juvenile Rehabilitation Administration (JRA)
  - JRA provides a continuum of preventative rehabilitative, residential and transition programs for juvenile offenders that holds them accountable for their crimes, protects the public, and reduces repetitive criminal behavior.
- Medical Assistance Administration (MAA)
  - MAA provides health care coverage to low income families and rate information for pharmacies and hospitals.
  - MAA is composed of five divisions and two offices.

- Regional offices are located in Tumwater, Renton and Spokane. Staff workers determine eligibility for Social Security disability programs for clients of all economic levels.

Two major computer systems, the Automated Client Eligibility System (ACES) and the Medicaid Management Information System (MMIS), must interact to generate payments to DSHS' vendors. The ESA operates the ACES. ACES contains the vast majority of eligibility data on the approximately 850,000 clients that DSHS serves.

DSHS uses the MMIS to pay medical claims and managed care capitated payments. Affiliated Computer Services, Inc. (ACS) is the current vendor that operates the MMIS. The MMIS relies on ACES for client eligibility data to determine whether and how to pay claims.

The ACES is a financial eligibility tool for workers in Community Service Offices (CSOs) to determine client eligibility for cash, medical and food assistance. The MMIS is a billing tool for providers to get paid for providing medical-related services. The only real similarity between the ACES and the MMIS is that the client base is the same, except for ITA and Take Charge clients who only reside in ACES. However, the purposes and users of the two systems are vastly different.

Following are some additional information items about the ACES:

- The ACES has a number of interfaces with other State and Federal agencies.
- There is a State Data Exchange (SDX) automated process for SSI applicants.
- The ACES sends benefits via EFT, Check and EBT. The ACES interfaces benefits to the Office of State Treasury (which then sends these to the bank) for EFT, as well as the benefits issued through Citibank. AFRS is then notified electronically for accounting purposes.
- The ACES generates client eligibility letters and Medical ID cards.
- The ACES was obtained from the State of Connecticut in 1992 and went live for the State of Washington in 1996.
- The ACES went through a re-procurement process in 2002. The structure of the contract changed, but the core system itself remained in place. The ACES vendor is IBM.

The following table lists the Medicaid funded programs that are currently paid through the MMIS:

Medicaid Funded Programs Paid through the MMIS

Administration or Division	Medicaid Funded Programs
ADSA (HCS)	Nursing Homes, Adult Day Health, Medical Transportation (Brokerage, Title XIX State Plan)
ADSA (DDD)	Medical and Dental Services, Institutional Services for the Mentally Retarded (IMR)
CA	Adoption – Medical Support
DASA	Outpatient Chemical Dependency Treatment, Residential Services for Medicaid Eligible Clients in Facilities with less than 17 beds, Support Services of Case Management and Therapeutic Child Care, and Ancillary Services of Urinalysis.
JRA	Chemical Dependency Disposition Alternative (CDDA) Assessments
MAA	Institutional, Professional, Dental, Optical, Pharmacy, Managed Care, Home Health, DME, Family Planning and Transportation Services
MHD	Involuntary & Voluntary Inpatient Mental Health

The following table lists the Medicaid funded programs that are currently paid through the Social Service Payment System (SSPS) or directly through AFRS:

Medicaid Funded Programs Paid through the SSPS or AFRS

Administration or Division	Medicaid Funded Programs
ADSA	Nursing: COPES, DDD Skilled, Delegation, Private Duty PACE Managed Care Program, Community Support, Family Support, Medicaid Personal Care Service for Children and Adults, Voluntary Placement Program, Medically Needy Waivers, DDD Home and Community Based Waiver, Day Program Direct Payments, DDD Group Homes, Nurse Aide Training, IP Orientation, Supported Living, DDD nursing oversight (A-19), Infant Toddler Early Intervention Program (ITEIP) (A-19), AAAs (A-19)

Administration or Division	Medicaid Funded Programs
CA	Behavior Rehabilitation Services (BRS), Medicaid Treatment Child Care (A-19), Personal Care Services for Children
ESA	SSI Facilitation/GA-X (including some limited transportation)
MAA	First Steps/Take Charge
JRA	Contracted Community Facilities - Behavioral Rehabilitation Services (BRS) (JV), Residential Treatment & Care Program (Title XIX eligibility pending)
MHD	Monthly Medicaid Capitated Payments (A-19), CLIP (A-19)

The following table lists the non-Medicaid medical programs that are currently paid through the SSPS or directly through AFRS:

Non-Medicaid Medical Programs Paid through the SSPS or AFRS

Administration or Division	Non-Medicaid Funded Programs
ADSA	DDD Community and Family Support*, Medicaid Personal Care for Children*, Voluntary Placement*, State Supplemental Payment (SSP), CHORE, Discharge Resources, Bed Holds, State Paid Adult Family Home (AFH) and ARC, Adult Protective Services, Financial Related
CA	Sexually Aggressive Youth*, Family Foster Care*, Adoption Support*, Behavior Rehabilitation*, Family Reconciliation Services*, Crisis Residential Center*
ESA	Refugee Medical Assessment required by INS
JRA	Medical and Dental office visits (A-19), Contracted Community Facilities (A-19)
MHD	Dangerous Mentally Ill Offender (DMIO), CSTC, SMHH, Court-Ordered Psychiatric Evaluations (A-19)
SCC	Medical/Dental (A-19)

Administration or Division	Non-Medicaid Funded Programs
DASA	Residential Services for clients in facilities with more than 16 bed, Group Care Enhancement Counselors, and Support Services – Housing Support and Interpretive Services

** Some payment codes*

Following is a list of non-Medicaid medical programs that are currently paid through the other methods and systems that are candidates for being paid in the new MMIS:

Non-Medicaid Medical Programs Paid through Other Systems and Methods

Administration or Division	Non-Medicaid Funded Programs
DASA	Low Income Outpatient Treatment Services and Interpretive Services

2.2 Needs

Needs that are not currently addressed are often labeled as an issue. As a result, the issues section provides a list of items identified during the process of developing this report. Many needs also have corresponding opportunities associated with them and are therefore also addressed in the opportunities area of the recommendations section.

There is interest by the Children's Administration (CA) and the Division of Alcohol and Substance Abuse (DASA) to create a confidential table in ACES. Only authorized users would be able to view foster care and alcohol and substance abuse clients. These clients would be exempted from the matching logic within ACES so that they cannot be identified through a match. Both CA and DASA appear open to utilizing ACES for this information if the appropriate levels of security are designed into the solution. MMIS security precautions are also necessary to ensure that only authorized users can view claims with certain procedure codes related to substance abuse.

The ACES to MMIS eligibility interface was originally designed in 1995 and has become problematic to maintain for both ACES and MMIS. There is a true need to simplify the interface process. Some work has already been done to improve the existing interface process.

The first action taken was a review of the current eligibility file record layout on the nightly ACES to MMIS interface. Some data elements that were no longer necessary were identified and removed. Additional data elements were added for client spend-

down, for Medicare Part A and Medicare Part B information, and for future expansion and growth of the MMIS. The remaining data elements were reviewed to see which data elements had triggers attached to them in ACES and to determine if the trigger was still necessary or if a trigger needed to be added. The data elements were divided into four sections; demographics, eligibility, spend-down and third party liability (TPL). The business rules for ACES were altered so that if there is a change to a data element in the demographics section it will trigger just the sending of that specific client's demographics record. If there are changes in the eligibility section, ACES will trigger both the eligibility and demographics records. Any changes to the fields in the TPL section cause ACES to trigger the TPL and demographics records. Due to the heavy amount of rejections in the MMIS it was decided that ACES would send only the most recent twenty-four (24) months of eligibility from the ongoing month. It was also decided to send only the information on the clients where a change occurred and not send all of the clients in the entire household just because one client had data that changed. This reduced the amount of unnecessary information being sent to the MMIS and helped reduce the number of rejected transactions by the MMIS.

A rewrite of the ACES to MMIS interface was completed in December of 2002. Extensive parallel testing began in July of 2003 and was completed in August of 2003. The current eligibility interface was implemented in August 2003.

The result of implementing the new interface was an immediate reduction in the number of rejected eligibility transactions by the MMIS when processing the ACES information. The size of the Eligibility Rejection Error Detail Report produced by the MMIS was reduced by half. In addition, the ACES to MMIS Reconciliation Report, also produced by the MMIS, showed similar improvement. The interface between the ACES and the MMIS has improved because the monthly reconciliation between the two systems shows a reduction in the number of clients that the MMIS did not receive from ACES. In July of 2003, MAA had to manually close 1,219 clients in MMIS because no ACES terminations had been received. In October of 2003 MAA only had to manually close 80 clients.

In early 2004 an electronic interface will be implemented between ACES and the MMIS to help improve the transmission of the nightly eligibility update by eliminating the current tape generation process and replacing it with a file transfer.

Following is the current flow of the ACES-MMIS Interface:

- Eligibility data is entered or updated in the ACES.
- The ACES sets trigger records that will be used to create the nightly interface file on tape (will be EDI in early 2004).
    - The ACES interface file generation process identifies changes in the past twenty-four hours that relate to medical.
    - The ACES then converts its program codes for identified records to values the MMIS accepts. These MMIS codes are the ones that were used in

Interactive Terminal Input System (ITIS), the eligibility system that preceded the ACES.

- Each night, the ACES creates an interface tape (will be EDI in early 2004) to transfer eligibility data to the MMIS.
- The MMIS has edit logic that governs which data to accept and the format the data must be in. The MMIS generates reports of rejected data that fail to meet the edit criteria.
- The MMIS also sends data to the ACES:
  - Weekly, the ACES accepts the MMIS interface file to update Long-Term Care vendors.
  - Weekly, the ACES accepts the MMIS interface file to update TPL information.
  - Monthly the ACES accepts the MMIS interface file to update the Medical ID card (MAID) information. Note: the ACES generates the MAID, even in the absence of the MMIS data. If, however, the MMIS sends the ACES a message on the interface file, the ACES will add the information to the MAID.
- The ACES inserts the data on the MAID from the MMIS interface and mails them to clients.
- The ACES creates a monthly MAID message reconciliation report. It identifies:
  - Clients who are active in the MMIS but are no longer active in the ACES and
  - applies only to managed care, TPL, restricted, DDD and Medicare clients.
- MAA staff use the monthly MAID message reconciliation report to manually correct the eligibility information in the MMIS.

2.3 Issues

Following are issues identified during the process of developing the ACES Interface Assessment Report.

2.3.1 Foster Care Assessments and Dental Services Issue

Many providers will not take medical coupons, so SSPS is used to pay these assessments from Foster Care (FC) dollars. FC had to raise the amount they would pay for these services to levels that are higher than Medicaid pays just to get an acceptable level of

provider participation. As a result, FC Medical-related payment history is not all in one place.

2.3.2 MMIS Eligibility Issue

A client's categorically needy (CN) eligibility start date is always the first of the month in ACES; whereas the MMIS allows a client's eligibility start date to be any day of the month. This first of the month start date issue is related to the next issue, mid-month program change (see 3.3.3).

GAU programs and Limited Casualty Programs (LCP) – Medically Needy Programs (MNP) can start mid-month in ACES. Many LCP-MNP clients have spend-downs. Coverage starts on the day spend-down is met. This can be any day of the month. ACES displays this actual eligibility start date.

2.3.3 Mid-month Program Change Issue

When a client changes to a new program mid-month, the ACES worker closes the original program and initiates the new one. In MMIS, however, the original program closes back to the end of the previous month and opens the new program in the middle of the month. The result is a gap in program eligibility in MMIS. MAA medical eligibility staff in the MMIS Services section of the Information Services Division (ISD) must manually correct the record. This is based on current eligibility policy rules. This could be changed in the ACES, if requested.

2.3.4 Same Day Eligibility Issue

A client requiring same-day services may apply for benefits at a CSO. If the client has all the documentation required it is possible for the CSO to approve their application that day. A temporary MAID can be typed and handed to the client. The client can then visit a participating provider for service. If this provider attempts to verify eligibility, this new client will not show in the MMIS as eligible.

2.3.5 Native American Status Issue

The services that DASA, as well as MAA, provides to Native Americans in tribal facilities, are eligible for a 100% federal match. The Native American statusl codes are maintained in ACES and interfaced to MMIS, but they are not currently used as an edit to pay claims for Native Americans at the 100% match rate. As a result, right now DSHS is relying on the provider to code the claim with a Native American indicator in order to claim the 100% federal match.

2.3.6 Lack of ITA Eligibility Data in ACES Issue

Services provided to clients who are eligible under the Involuntary Treatment Act (ITA) are paid through the MMIS but these clients are not known to ACES. The County Designated Mental Health Professional (CDMHP) fills out a 13685 form in the field. The providing hospital, ambulance service, pharmacy and medical vendor providers must attach the form to the claim they submit to the MMIS. Services provided in these cases result from court orders so some patients are not Medicaid-eligible but still must be entered directly into the MMIS by the MAA Eligibility group.

2.3.7 Lack of PACE Eligibility Data in ACES Issue

HCS workers enter the Program of All-Inclusive Care for the Elderly (PACE) information in the MMIS. The ACES only shows that the client is Medicaid eligible.

2.3.8 Assessments Paid Through SSPS Issue

Many medical and psychiatric assessments are paid through the SSPS. Some Re-certifications are paid through SSPS too. For example: General Assistance SSI Facilitation – sometimes a psychiatric evaluation is needed for someone who is a candidate for SSI that Medicaid will not pay for. The assessment/evaluation must be performed, and these are paid through SSPS rather than MMIS. The result is that not all medical-related information is viewable for a client within the MMIS.

2.3.9 Client Registry Issue

Probably twenty percent of the CSO workers utilize the DSHS Client Registry system on a somewhat regular basis for case management purposes. The challenge is that with so many different systems available to the workers, keeping track of their ID and password for each application they utilize becomes cumbersome. Therefore most workers have just two or three systems they use regularly. In addition, the Client Registry case management data can be up to one month old depending upon the source.

The intent of the Client Registry system is to encourage caseworkers to talk to one another. Right now they just get a phone number of another agency caseworker. Some people do not like using the Client Registry because they are used to getting all of the data off the screen rather than just a contact.

Client Registry is an official DSHS project. A study was performed within DSHS and the existence and need for the Client Registry system was validated.

The Children's Administration workers use the Client Registry system during off-hours because ACES is not a 24x7 system.

Mental Health Regional Support Network (RSNs) would like up to date Medicaid eligibility data prior to rendering services. Current ACES data provided by the Mental Health Division (MHD) is monthly and often not current enough. The RSNs would like to use the Client Registry, but current policy and federal regulations for DASA clients restricts Client Registry to use by DSHS staff.

The Client Registry system has some interesting potential use within DSHS. To be fully embraced by the workers it will need to get more timely access to data and streamline the login process perhaps by allowing a one-step sign-on by trusting the application that is linking into it for access. An example of the one step integrated login that is already in place is the link to Client Registry from the online JOBS Automated System (e-JAS).

More timely access to other systems eligibility data is important to maximize the effectiveness of the Client Registry. The challenge is getting this data interface prioritized by the other systems, as it may be perceived as added work for their systems staff with no immediately recognizable benefit to their system. The benefits could be realized by DSHS as a whole.

2.3.10 Newborn Receives Mother's Identifier Issue

Infants who do not have their own identifier by default pick up their mother's identifier in the MMIS. This can result in claims being paid under the incorrect funding source. For example, consider non-citizen pre-natal care. The mother may be Title XXI eligible but the newborn is Title XIX eligible. As a result claims for the newborn without an identifier would be paid under Title XXI with the mother's identifier rather than Title XIX.

2.3.11 ACES Users Create Multiple Client IDs for the Same Person Issue

Multiple names can be associated with a single SSN in ACES. The result is that ACES creates multiple client IDs for the same person when that individual has different names entered. ACES users should not be assigning new client IDs for the same individual. There is a capacity in ACES for IDs to be merged. The scenario of multiple client IDs for the same person appears to be primarily a training issue. Further investigation is needed to fully realize the opportunities of a single client identifier between ACES and the MMIS.

2.3.12 Dual Coverage Issue

Medicare information is not always being data entered by the Community Services Office workers when a new Medicare eligible client is activated. As a result MMIS is not handling spend-down data correctly for these dual-eligibles so some clients are staying on Medicaid when they should have been converted to Medicare. Since there is the

potential for cost savings for the Department, this issue can be addressed in the near future rather than waiting to address it during the implementation of the new MMIS. This appears to be a training issue.

2.3.13 Medically Needy (MN) Program and Spend-down Issue

There appears to be a need for DSHS to clarify the policy on Medically Needy Spend-down to address growing complaints from providers.

Clients who are aged, blind or disabled with income in excess of Categorically Needy (CN) medical standards may participate in the Medically Needy program (MN). MN is an optional Medicaid program, which usually requires the client to meet a "Spend-down" liability. Clients must incur bills equal to the amount of monthly income that exceeds the CN standard (currently $571) calculated for a base period of either three or six months.

Clients who incur a hospital bill, which meets or exceeds their Spend-down expense, are eligible for DSHS paid medical coverage from the first day of their base period. Providers are not required to reimburse clients and bill Medicaid unless they knowingly billed a Medicaid client. If client eligibility for Medicaid is determined after the billing, the provider has the choice of reimbursing the client.

Other clients are not eligible for DSHS paid medical coverage until the actual day they meet their Spend-down, often with bills for prescription drugs. This "partial month" eligibility is confusing for clients, workers and pharmacy providers and needs to be clarified.

Originally, DSHS covered clients from the day and time they met their spend-down ("partial day") eligibility. This policy was very cumbersome to administer and, as a result, DSHS modified the policy to start coverage at 12:01 a.m. of the day the client met their spend-down ("partial month") eligibility. This change solved some but not all of the problems with the program.

The following concerns still exist:

- **Pharmacies**[1]**:** Pharmacies often encounter the following scenario:
  - A client who has not yet met their spend-down liability fills a prescription at a pharmacy and obtains a bill. The client then brings the bill to the CSO to show that they have met their spend-down. The CSO issues the client a medical ID card, which the client brings to the pharmacy. If the client has not yet paid for the prescription, the pharmacy can proceed to

bill DSHS. If the client has already paid for the prescription, the client may ask the pharmacy to reimburse them and bill DSHS. In this scenario, a client can incur a spend-down but is able to avoid financial liability.

- Pharmacy concerns about this approach include:
  - Some pharmacies feel that the spend-down liability is an obligation that the client should pay. "Working" the system in this fashion seems like fraud to some. Furthermore, it is inequitable to clients who actually pay their spend-down liability.
  - Providers are also concerned that billing DSHS for bills used to meet the spend-down liability will open them up to negative audit findings and could be grounds for recoupment.

- **Advocates:**[2] Columbia Legal Service (CLS) strongly supports a client's right to receive paid services as well as reimbursement of bills paid by the client prior to approval of the partial month eligibility. Their publication, Medicaid for adults 65 and older or disabled who do not get SSI, can be found online at http://www.nwjustice.org/pdfs/5104.pdf. CLS wants DSHS to support the current approach in writing so they can train the community.
- **Community Service and HCS Offices:** CSO and HCS workers express confusion and frustration regarding spend-down requirements versus practices.

[1]WAC 388-502-0160 tells a provider they may "*bill the client*" when the bill counts toward a spend-down liability. 42 CFR 435.831 (g) states that expenses used to meet spend-down are not reimbursable under Medicaid. To the extent necessary to prevent the transfer of an individual's spend-down liability to the Medicaid program, States must reduce the amount of provider charges that would otherwise be reimbursable under Medicaid.

[2]WAC 388-519-0110 explains calculation of spend-down. WAC 388-416-0020 describes the first of the month rule as well as partial month; it also alludes to partial day, given the provider's ability to bill the client for expenses used to meet spend-down, if those expenses are incurred the day spend-down is met. CLS contends that clients are entitled to reimbursement for any paid services received on the day spend-down is met, including those used to meet spend-down.

Note: A significant portion of the information in this issue was cited from the document titled 'Medically Needy (MN) Program and Spenddown (11/12/03)' (see Appendix – References for additional information).

3. Findings from Other State Medicaid Agencies

Medicaid is not a uniform program nationwide. Federal guidance establishes a broad framework, but each state has latitude to shape its own program. The national political and fiscal environments also affect Medicaid administration, where a change in who controls the executive branch or Congress, as well as changes in federal revenues, can affect the direction or speed of federal Medicaid decisions. Below are findings from some other states regarding their Medicaid Eligibility Determination Process.

3.1 Minnesota

The State of Minnesota and the State of Washington are similar in that both have very complex Medicaid programs. Minnesota, for example, has more than one hundred different eligibility programs.

The State of Minnesota elected to develop a new Automated Health Care Eligibility System. The process for identification of alternatives for the new system was organized into three main strategies:

- Identify an existing solution that generally meets the health care eligibility determination requirements, and then transfer that solution to Minnesota with the modifications to meet specific requirements.
- Modify one of the Department's legacy systems to provide the functionality for the MinnesotaCare high-payback areas.
- Custom-build a system specifically designed to meet the Department's requirements for the MinnesotaCare high-payback areas to form the foundation for a comprehensive health care eligibility system.

The State of Minnesota elected a custom solution. They felt a custom solution would permit the architecture for the Health Care Automation Eligibility System to be designed to take advantage of emerging technologies. The State performed a return on investment (ROI) study. The looked at and evaluated the time spent by county workers on manual processes. The findings from the study showed that in less than five years the system would pay for itself.

The State of Minnesota's FAMIS eligibility system is called MAXIS. MAXIS came from the State of South Dakota. MAXIS went live for the State of Minnesota in 1990. This eligibility system was designed for cash and food stamp programs. When MAXIS went live, Medicaid medical eligibility was still being performed via data entry forms for the MMIS. The eighty-seven (87) counties in Minnesota expressed concern about this split

in methods for determining eligibility. As a result, a decision was made to add some FAMIS functionality for medical eligibility. Over the years health care eligibility functionality has been added to MAXIS.

When the Children's Health Insurance Program (CHIP) came about the State of Minnesota decided not to put it into MAXIS and rather elected to use MAXIS only for client identification (name clearance). Determination for eligibility was done offline and then manually entered into the MMIS. The MMIS at that time was a mainframe COBOL/VSAM architecture, and there was not a complete interface between MAXIS and the MMIS. The current Minnesota MMIS went live in 1994.

For Minnesota Care everything was added manually. The State would have preferred an automated process, but there were no funds to change it.

The State of Minnesota wanted to improve their medical eligibility process and decided to pursue an approach that used an insurance-like model rather than a welfare model. In 1999, KPMG studied MAXIS and MMIS. The resulting recommendation was to put in a stand-alone eligibility system just for health care.

The Steering Committee reviewed the recommendations and asked the legislature for approval of a new health care medical eligibility system. This request for a system was initially just for MinnesotaCare (managed care program). It was decided that servicing only the MinnesotaCare program was not enough. There was also a need for the system to serve the fee-for-service Medicaid clients as well. In addition, there was a desire to extend the outreach and exposure of State Health Care Programs to the needy population.

Around this same time there was a lawsuit in Minnesota that required improving access to the programs and making the information available in multiple languages. The Steering Committee took the initial KPMG recommendation and expanded it to include all State health care programs. Because Long Term Care (LTC) and waiver programs could take years to implement, Minnesota decided to start with health care programs for families with children.

The State of Minnesota put out a Request For Proposal (RFP) in May 2002. Nine different acceptable vendors provided proposals. Three finalists were selected. Even though KMPG had put together the initial recommendation, they were also allowed to bid. The contract was awarded to SSI North America. SSI had developed @vantage for the State of Wyoming. SSI also had experience in Massachusetts and with web technologies. The State insisted on a performance-based contract, and the contract was finally signed in May of 2003 and work began in June of 2003.

It should be noted that there was a joint development requirement for this health care eligibility system, so some vendors chose not to bid. Health match will function as a component of the MMIS. The State is receiving a 50% match for the pure eligibility portion of the project and a 75% percent match for the MMIS eligibility subsystem.

In July of 2003 the joint application requirement (JAR) sessions were held. The JAR sessions finished in December of 2003. The project is now in the joint application design phase. The current sessions involve the design of the interface between the cash/food stamps eligibility system and the health eligibility system.

County workers will be accessing the new health eligibility system through the web. There will be an online application via a web portal. There will be a decision tree model for the online application. The online application is being built under a separate contract. The online application will be deployed before the health match system is deployed.

The project is not without its challenges. The State of Minnesota is struggling with separate systems for eligibility input. Because the majority of the State's money is spent on health care dollars and because Minnesota does not have a "no wrong door" policy, the State has elected to concentrate on health eligibility.

The system requirements have been more complicated than anyone imagined. The health eligibility proof of concept is due out in the spring of 2004, and a limited pilot is scheduled for late fall 2004. A phased implementation is planned for 2005. There has been some discussion about expanding beyond just families with children.

Because of the complexities of health care, the State of Minnesota felt they would have been in analysis paralysis if they had tackled all eligibility determination. From a project management perspective it would have been easier, but it was not realistic with today's political climate.

HIPAA presented an opportunity for Minnesota to move away from COBOL/VSAM to a relational database environment. Minnesota took advantage of this opportunity. This move to a relational database architecture better positioned the State to take advantage of newer technologies for the health eligibility system.

3.2 Colorado

The new Colorado Benefits Management System (CBMS) will make a "Medicaid Eligibility Determination" based on data entered into CBMS by eligibility workers. Once CBMS has determined eligibility, CBMS will interface with Colorado's MMIS daily to exchange data and to make payments, as appropriate. CBMS is currently scheduled to go live at the end of April 2004.

Colorado decided after much investigation and research to keep Medicaid Eligibility Determination outside of the MMIS and instead concentrated on consolidating six separate legacy eligibility determination systems into one integrated statewide system.

Colorado clients will still face same-day eligibility issues. Eligibility is determined by CBMS when the client completes an application with a CBMS worker; the interface to MMIS is an overnight interface, meaning that the MMIS (and other eligibility verification systems that are downstream from MMIS) does not have the eligibility information until the next day. So if a client takes a temporary card directly to a provider, they will not have access to those benefits until the next day. The eligibility verification system connects to the MMIS, not to CBMS.

At this time the CMBS is designed to support a nightly interface with the MMIS. A real-time or near real-time eligibility interface between the CBMS and the MMIS would likely eliminate or significantly reduce the number of same-day eligibility client issues that arise.

4. Recommendations

After participating in the JAD process, conducting extensive one-on-one interviews with stakeholders, and reviewing findings from other State Medicaid agencies, it is FourThought Group's recommendation that Medicaid Eligibility Determination continue to be performed by the ESA utilizing the ACES. With that said, improvements are necessary to streamline the ACES-MMIS eligibility interface.

The State of Washington is in an interesting position in that the ACES is an Aid For Dependent Children (AFDC) era eligibility system utilizing FAMIS codes. The current MMIS utilizes Interactive Terminal Input System (ITIS) codes. This difference in codes and the resulting "crosswalk" for translation is causing the bulk of the eligibility related problems. As a result there is a definite need to eliminate this "crosswalk" of codes and utilize the same codes within the ACES and the new MMIS.

If the new MMIS is designed to utilize the ACES eligibility codes, DSHS must keep in mind they are making a conscious decision to design their new MMIS to match a FAMIS model eligibility system, which for all practical purposes is one generation behind the current generation TANF model eligibility system. In general, State eligibility systems in the late 1980's and early 1990's were constructed with FAMIS funding and a focus on eligibility for AFDC and Food Stamps. The Washington ACES has been retrofitted to support TANF and does so today, so support for TANF will be there in the future. However, it should be known that ACES was not originally designed for TANF support. Eliminating the crosswalk and utilizing consistent codes between the ACES and the MMIS will address the bulk of the current eligibility related problems between the systems.

Some careful analysis needs to be performed to ensure that the ACES coverage groups are detailed enough to support the MMIS program, match and medical eligibility codes. ACES will require an enhancement to maintain one additional level of eligibility granularity to meet the goal of having the new MMIS actually be able to directly utilize the ACES eligibility codes. The new MMIS needs the detail that breaks down into the current Medicaid eligibility code, as the current medical coverage groups in ACES do not provide the detailed information needed for MMIS to receive the specific data for funding for the services. For example, a person with an F01 identified coverage group could be receiving either Medicaid or State funded medical assistance.

Another area of concern relates to the client identifier. Today the ACES and the MMIS use two different client identifiers. The ACES client identifier is a system assigned next available unique number. The MMIS utilizes a personal identification code (PIC) for the identifier. The PIC is comprised of last name, date of birth, and some additional logic. As a result of the MMIS PIC design, a single individual may have multiple PICs over time. The ACES client identifier should be strongly considered for use as the client identifier in the new MMIS. Having a single client identifier shared between ACES and MMIS will make it much easier to identify those receiving duplicate services.

Addressing the elimination of the crosswalk through the consistent use of codes between ACES and the new MMIS along with a single client identifier shared between the systems is the most cost effective method for improving the Medicaid Eligibility Determination issues. The same day eligibility issue would still exist if the interface were to remain daily. DSHS may want to consider the opportunity of utilizing the Operational Data Store (ODS) with the new MMIS. ODS provides the infrastructure that will allow ACES to mirror its database. The ACES utilizes DB2, a relational database, and it could be used either directly by the new MMIS or the new MMIS could simply pull in the data it requires on an as needed basis or with a regular update such as hourly. Data integrity edits should be in place to ensure the validity of the incoming eligibility data.

It is important to note that the current ACES-MMIS interface is very complex. As a result, when implementing the new MMIS plenty of lead-time needs to be allowed for design of the new ACES-MMIS interface. The last experience with making changes to the current ACES-MMIS interface took approximately one year to complete.

Alternative options were considered including combining the Medicaid Eligibility Determination process into the MMIS. If combined, the new MMIS at a minimum would need to be able to:

- Determine financial eligibility which is already in place with the ACES;
- Determine appropriate billing categories and funding sources which is already defined and in place with the ACES;
- Provide additional federal and state eligibility and accounting related reports already present in ACES;
- Have an access point at all of the local welfare offices, hospitals, clinics, and other designated outreach locations;
- Replicate interfaces and lookups with other State administrative systems that are used and accessed by workers in the eligibility determination process. This functionality already exists in ACES. Following is a list of the actual interfaces currently in place with ACES:
    - Citibank: EBT
    - DSHS: BARCODE
    - DSHS: Case and Management Information System (CAMIS)
    - DSHS: Central Accounting – Office of Accounting Services
    - DSHS: Client Registry
    - DSHS: Income and Eligibility Verification System
    - DSHS: Division of Child Support
    - DSHS: EBT Office
    - DSHS: JOBS Automated System (JAS, e-JAS)

- DSHS: Office of Financial Recovery
- DSHS: Office of Public Assistance Data Analysis
- DSHS: Social Services Payment System (SSPS)
- Federal: Bureau of Indian Affairs
- Federal: FNS – Disqualified Recipient Systems
- Federal: Housing and Urban Development
- Federal: Internal Revenue Service
- Federal: SSA: Beneficiary Data Exchange (BENDEX)
- Federal: SSA: Medicare Buy-In
- Federal: SSA: NUMIDENT
- Federal: SSA: State Data Exchange (SDX)
- Federal: Public Assistance Reporting Information System (PARIS)
- Washington State Agency of Financial Reporting System (AFRS)
- Washington State Auditors Office
- Washington State Department of Community Trade and Economic Development
- Washington State Department of Employment Security
- Washington State Department of Health
- Washington State Department of Labor and Industries
- Washington State Department of Personnel
- Washington State Office of State Treasurer
- Washington State Office of Superintendent of Public Instruction;

- Generate client eligibility letters and MAIDs;
- Replicate or integrate the features of the BARCODE system currently in use at the CSOs;
- Provide access to the MMIS at each of the CSOs or put MAA field staff in place throughout the state that would have access to the MMIS;
- Provide training to representatives regarding how to use the MMIS eligibility application;

These requirements, in addition to complicating the “no wrong door” policy embraced by DSHS, contributed to the recommendation to keep the ACES for eligibility determination. It is FourThought Group’s recommendation that DSHS concentrate on consolidating

Medicaid eligibility determination into the ACES wherever possible, improving the interface between the ACES and the MMIS, and commit to a single client identifier.

It is important to note that medical assistance is not Medicaid. Medical assistance is only about sixty-two percent of Medicaid payments. The other thirty-eight percent is comprised of nursing homes, DASA, mental health and other programs. Identifying the MMIS for medical eligibility is not sufficient. Determining Medicaid eligibility within the MMIS has tremendous inherent complexities that are already addressed in ACES. It appears to be most cost effective for DSHS to improve the technical and procedural interfaces between ACES and MMIS rather than trying to recreate a portion of the ACES eligibility determination logic in the MMIS.

5. Potential Impacts to ACES

The following items have been identified as potential impacts to ACES in the process of developing this report. These items should be carried forth by the MMIS Re-procurement team. Some of these items may become requirements for the new MMIS while others can be addressed during design. Still others may require executive level decisions to be made.

5.1 Consider ODS for Real-Time Access of ACES Eligibility Data

The Operational Data Store (ODS) should be considered for a more real-time pickup of ACES eligibility data. ODS could offer a near real time mirror of ACES eligibility data for MMIS. It currently has 18 months of data available but could be expanded to include more. MMIS could then use this data directly or pull it on a frequent basis such as hourly. Moving to a near real time interface should address many of the data lag related issues currently experience with the nightly interface between ACES and MMIS.

A potential opportunity exists for the ODS to publish a web service that could meet MMIS needs while beginning to create a DSHS environment that allows and encourages legacy systems to communicate and exchange data in a near real-time fashion.

5.2 Single Client Identifier

Move to a Single client identifier between ACES and MMIS utilizing ACES as the system that creates the identifier (MMIS PIC codes go away).

DSHS may want to consider ACES as the single point for generating client identifiers for all DSHS programs. The ACES has interfaces with SSA and other entities for the purpose of accurately matching identities. The client data would not necessarily need to be maintained in ACES for all programs. The client could simply be identified in ACES and assigned a DSHS unique identifier.

The FACT Screening Tool, in early pilot with ESA and CA, if automated as a universal intake, may offer the opportunity to issue a state wide unique identifier that all DSHS systems can use. This would require that all DSHS administrations be involved in the design and development of the screening tool to ensure that it meets their needs for data collection and availability.

5.3 Eliminate ACES-MMIS Crosswalk

Eliminate the ACES-MMIS interface crosswalk by having the new MMIS utilize the ACES set of eligibility and program codes. Some careful analysis needs to be performed to ensure that the ACES coverage groups are detailed enough to support the MMIS program-match and eligibility codes.

5.4 Make DASA Residential and Low-Income Outpatient Payments through MMIS

Make DASA residential and low-income outpatient payments through the MMIS with either a link to the TARGET system or a download from TARGET into ACES so they interface into the MMIS. The majority of the providers are already Medicaid providers. Counties would still manage the clients, but providers would be paid out of the MMIS. Providers would submit claims into the MMIS. Today each county handles payment arrangements themselves. This new model would force everyone into a FFS model and standardize rates across the state.

5.5 Bill DASA Interpreter Services through MMIS

Currently, DASA is not receiving any Medicaid match on interpretive services because of the system that is set up (i.e., the way the contracts were written with interpretive services). However, interpretive services for Medicaid clients are eligible for federal matching dollars. This could increase DASA's federal earnings by a couple hundred thousand dollars a year. Billing for interpretive services through the MMIS would make for a much more accountable system. Providers would bill their claims through the MMIS and those services provided to those who are not Medicaid eligible would be coded with state only funding.

5.6 Make DASA Group Care Enhancement Payments through MMIS

DASA pays for a FTE of a counselor. Most clients are Medicaid eligible. To date DASA has not been able to structure a FFS payment in such a way that would make sure that they have enough money to pay for that FTE. Right now the counselor is paid on an FTE basis (number of hours of client contact). If DASA could move to a FFS model they could get Medicaid match dollars. The challenge is that not all those being serviced are Medicaid eligible. DASA would need to identify each client and then, if billed through

MMIS, DSHS could get matching funds for those that are Medicaid eligible. Others would fall into the state-only funding category.

5.7 Track Client Zip Code at Time of Service

Keeping the client zip code at time of service is needed for the Mental Health Division (MHD) and DASA. This historical data is needed to identify which RSN the client was associated with at the time of service. For example, to calculate MHD payments and assign claims to RSNs from the MMIS, there are currently some challenges/difficulties with RSN disputes (moving the claim from one RSN to another RSN). It would be nice to see who the RSN was for a claim at the time the claim was paid and provide a full RSN history including past movement. (See zip code at time of service opportunity below.) This could be accomplished in a couple of ways, one of which is simply to include a historical effective date for an address. Changes to ACES will be necessary.

5.8 Consider FACT Screening Tool for Unique State Identifier

The FACT Screening Tool, currently in an early pilot phase, is a joint project for ESA and CA and may provide the source of a future opportunity for the DSHS to move to a single client identifier across all systems. This could be done if the screening tool were automated and adapted to serve as the initial entry point and screening tool for all contacts with applicants. This tool could potentially assign the Washington state unique identifier. Significant changes to ACES and other DSHS systems would be necessary to implement the FACT Screening Tool as the generator of a unique state identifier.

5.9 Create CMIS-MMIS Interface for Managed Care to FFS client changes

When a client changes from a managed care program to a fee for service (FFS) program, this information is entered into the Client Management Information System (CMIS). There is no interface between CMIS and MMIS so a worker must also remember to go into MMIS and update the client's eligibility segment. The MMIS will then update the program eligibility and generate an automated recoupment for the managed care premium. An interface between CMIS and MMIS could be developed to automate the eligibility program change. Some analysis should be done to see if this eligibility data could flow into the MMIS from ACES through a CMIS-ACES interface.

5.10 HMOs Accept Pro-Rated Premiums and Mid-Month Enrollments

Establish the ability to re-enroll a client mid-month immediately into a health maintenance organization (HMO) and update the Point of Sale (POS) system with this mid-month enrollment information. This would require HMOs to accept pro-rated monthly premiums.

5.11 Allow Different Reimbursement Rates for Different Administrations

Set up a different reimbursement rate in MMIS for Foster Care (FC) medical assessment claims that pay the higher FC reimbursement amounts. Other administrations could have their assessments and related claims paid through the MMIS as long as they could code the rates and the proper funding source is identified for accounting purposes.

5.12 Enhance ACES Security to Accommodate Foster Care and DASA Needs

If security concerns were addressed in ACES, it could be used for Foster Care and DASA eligibility needs. The logic would know that Foster Care or Substance Abuse clients cannot be linked together with any other client and these clients would be excluded from all matching logic.

5.13 Remove State Tracked Expedited Food Assistance Appointment Letters from BARCODE

All appointment letters that require State tracking of expedited food assistance dates should be deleted from BARCODE and only be made available in ACES. BARCODE does not currently have the necessary letter date tracking to meet state requirements. An alternative is to enhance BARCODE to meet the state reporting requirements for food assistance letters. However, it should be noted that denial letters are generated out of ACES and therefore consolidating all letters related to expedited food assistance in ACES is recommended.

5.14 Link all "Jumped Tracks" in ACES for Eligibility Determination

Link all "jumped tracks" so that all programs are checked. (For example, family medical and pregnancy cannot cross. Another nice feature would be that when someone applies, the user could select medical and ALL medical-related services would be checked for eligibility). It should be noted that this would likely require extensive changes to ACES. This change will also require agreement by stakeholders outside of MAA as it would impact other DSHS administrations.

5.15 Provide ACES with DDD Information

The ACES does not know when someone is a Division of Developmentally Disabled (DDD) client. It may be possible to get an interface file back to ACES and carry this information.

DDD would like to be able to query specific client information out of ACES including client income, family income and type of income. DDD may also benefit from the use of specific ACES codes to capture a particular subset of their population.

DDD currently has a six-digit client identifier that is used to track client data including services, location, history, program type and more. Unless DDD utilizes the ACES client ID, the six-digit DDD identifier will need to be carried in ACES as a cross-reference to easily access these DDD clients.

This change will also require agreement by stakeholders outside of MAA as it would impact other DSHS administrations.

5.16 Report to Identify MMIS FFS Clients not in ACES

Develop a report that will identify Fee-For-Service (FFS) clients who are eligible in MMIS but not in ACES.

5.17 Make MMIS Program Match Code Viewable in ACES

Make the MMIS program match code viewable in ACES. This would be unnecessary if ACES and MMIS utilize the same sets of codes.

5.18 Modify ACES for Concurrent Medical Programs

Modify ACES to permit two or more concurrent medical programs. It should be noted that this would likely require extensive changes to ACES.

5.19 Consider Real-Time Spend-down Data for Eligibility

Consider the possibility of housing real-time spend-down data for eligibility.

DSHS could pay for all expenses that occur on the day the client meets spend-down, including those expenses used to meet spend-down liability. If, however, the client has already paid for the service, the provider would have the option to either reimburse the client and bill DSHS, or not reimburse the client and not bill DSHS. To implement this policy, DSHS would need to:

- Issue a provider memo clearly stating this spend-down policy;
- Send a memo to the CSO/HCS staff clearly stating this spend-down policy;
- Update the EA-Z manual worker instructions for spend-down; and
- Revise the "Billing The Client" WAC to clarify that providers may not bill clients for any services received on the day spend-down is met;

> *Note:* A problem with the above solution arises when a client incurs a bill that is greater than their remaining spend-down liability. For example, a client might owe $100 in spend-down liability, but incur a bill for $200 of prescriptions. In those cases, DSHS would need to pay a portion and the client would be responsible for a portion. It should be noted that the current system does not permit pharmacists to split bills in this fashion. This should be considered for the new MMIS if the long-term solution is not implemented.

A longer-term solution would be to create an automated system to track spend-down. DSHS has already estimated systems design and development at two to four years. This would logically require implementation of the Medical ID "swipe card" and the new MMIS to track the spend-down liability. With this solution, DSHS would allow the provider to bill DSHS and be denied until the spend-down is met. (See Electronic Swipe Card below in this opportunities Section for more information.)

Moving to a real-time spend-down model also has the benefit of staff efficiencies. No longer would clients have to bring in receipts to staff workers to justify that spend-down has been met.

Note: A significant portion of the information in this recommendation was cited from the document titled 'Medically Needy (MN) Program and Spenddown (11/12/03)' (see Appendix – References for additional information).

5.20 Display HMO Enrollment in ACES

Instead of having workers look at the MAID for HMO Enrollment, allow workers to view this information online in ACES.

5.21 Develop an Interface between TARGET and ACES

Create an interface between TARGET and ACES to get DASA eligibility into ACES. Having DASA eligibility data in ACES will be necessary in order to utilize the new MMIS as a payment system for DASA services.

5.22 Process CLIP Payments through MMIS

Children's long-term inpatient program (CLIP) payments are currently made with an A-19 through AFRS. Reimbursement is based on the submitted client days. This process is a candidate to go through the new MMIS as are the following MHD programs currently paid through AFRS (A-19): DMIO, CSTC and state hospitals medical payments, and court ordered psychiatric evaluations.

5.23 Automate DDD-MMIS Eligibility Interface

DDD determines eligibility and currently sends information to MMIS Services through fax and e-mails. In addition, once a month, a report of new DD clients or clients who have been terminated is sent to MMIS Services. This report includes the effective and end dates of the clients' DD eligibility. It appears that much of the data in DDD doesn't match the information in MMIS. These processes should be considered for automation.

5.24 Consider a Single Integrated Statewide Eligibility System

Consider consolidating all state eligibility into one integrated statewide system. Short of this, DSHS should architect a roadmap for a means of allowing the disparate heterogeneous systems to communicate with one another and concentrate on a single client identifier to more easily link the data in these separate systems.

5.25 Integrate Eligibility Data into ACES

There are a few systems that determine eligibility separately from ACES (e.g., DASA, DDD eligibility, JRA and DVR). DSHS may want to look at ways to integrate their data into ACES before the MMIS re-procurement.

5.26 Track General Assistance Assessments through MMIS

General Assistance (GA) authorizes assessments to determine if the client can work. GA pays for evaluation services for verification. There appears to be an opportunity for DSHS to save money by housing the assessment data in the MMIS because a client is only entitled to one assessment opinion. Currently, GA does not have any automatic edit to prevent repayment of another assessment. This could be more easily implemented in the MMIS to prevent payment of more than one assessment. Exam rates are set by program policy but other services such as lab work are paid based on MAA rates. Social workers have to determine payment manually and therefore there is an increased potential for errors. In addition, there is a monthly letter that goes out asking clients if they have been seeing their doctor regularly. This letter has print and postage costs and imaging costs. If services were in the MMIS, the social worker could tell if a client has been seeing their doctor regularly and send letters only when warranted.

Pending GA clients are in ACES and could be added to the MMIS interface to facilitate the housing of assessment data in MMIS.

5.27 DDDS Eligibility Determination in the MMIS

If all medical care history was stored in the MMIS, DDDS could determine disability from history. DDDS would not have to rely on the client providing this information.

5.28 Track and Pay Refugee Health Assessments through MMIS

The A-19 for paying refugee health assessment could go away and be paid out of the MMIS. During the first ninety days after arrival into the country, refugees undergo health screening and complete form I-693 as mandated by BCIS (Bureau of Citizenship and Immigration Services), formally known as INS, refugee status adjustment. RIA (Refugee & Immigrant Assistance) contracts with Health Districts for refugee health screening that could contain about 36 different procedures. The majority of health screenings are completed within the first three weeks after arrival and by then the only identifier that refugees have is their Alien number. Though most refugees (approx 90%) apply for assistance and end up in ACES, health screening is not a part of their eligibility requirements for TANF/RCA. Refugees are automatically eligible for Medicaid, and this would centralize their health records.

5.29 Enter ITA Clients into ACES

ITA clients never reside in ACES; they reside strictly in the MMIS. MAA eligibility workers manually try to search and match ITA Medicaid clients. They search MMIS as well as other DSHS systems looking for a match. If there is no client match on file the client is manually added into MMIS. For consistency, these clients could be added to ACES by the MAA eligibility workers and then interfaced to MMIS.

This approach is further justified by the fact that later, if this client does show up on ACES for another program, their eligibility information in the MMIS is overlaid with the eligibility data from ACES in the interface process. Had the ITA eligibility data been resident in ACES, it would not have been lost in the interface process.

There are some unique circumstances for ITA clients that must be considered. For example, oftentimes the clients do not use their real names, or birthdates or social security numbers. Identifying the client is a known problem. In addition, ITA eligibility is often good for just one day.

5.30 Automated Mass Adjustments

For changes in retroactive eligibility, DSHS may want to consider having an automated mass adjustment process that automatically pulls all affected claims by the change in eligibility. The mass adjustment process should provide DSHS with the opportunity to selectively review and submit the selected claims for reprocessing. Each claim being reprocessed should set up an account receivable for the amount of the original payment and have the adjusted claim first satisfy that receivable and then satisfy any other outstanding receivables for that provider before issuing out monies.

5.31 Issue Electronic Swipe Cards

DSHS currently prints and mails nearly 500,000 paper Medical Assistance ID (MAID) cards to clients each month. The MAID identifies program and match codes, effective dates, any provider restrictions, HMO (if any), and other similar information. DSHS accepts a copy of the MAID as proof of eligibility, even if the client loses eligibility before the MAID expires.

Electronic eligibility verification is currently provided by third party Medical Eligibility Verification (MEV) vendors to providers at a cost of $0.25 - $0.40 per inquiry (depending on volume) and is generally paid by the provider. Authorized vendors receive eligibility information directly from the current MMIS and there is approximately a forty-eight hour delay before eligible clients show on the system. As an alternative, there is a new web site in place for providers to look up medical eligibility from the MMIS free of charge.

5.31.1 Opportunities

- DSHS issues a permanent, plastic, magnetically encoded identification card in place of the paper MAID. This card would be issued once to a client and serve as their permanent ID Card. Replacements for lost, stolen, or mutilated cards would be available.
- The current procedure of notifying clients of a change in their benefits by letter correspondence would continue.
- The provider would swipe the card and receive information on client eligibility, third party liability, and other eligibility-related data. Client eligibility should show in the new eligibility verification system timely, rather than the forty-eight hours required by the current eligibility verification system.
- Providers should have multiple ways to obtain eligibility information:
  - Use the swipe card;
  - Log on to a secure website and request information. The website should include a site for batch requests; or
  - Call an Interactive Voice Response (IVR) line.

5.31.2 Advantages

- Improved Service. Provides 24/7 access to eligibility data in near real time, increased ability to manage Medicaid reimbursements, and consolidates eligibility information. MAA processes the claim more quickly due to the

eligibility authorization number on the claim, and the provider receives prompt adjudication of the claim.

- Aligns with HIPAA. HIPAA requires the development of eligibility data access and distribution of that data.
- Builds the foundation to further enhance eligibility management. Once in place, an electronic swipe card will allow DSHS to simplify spend-down program and link with handheld devices.
- Enhances Client Relations. Eliminating the monthly paper ID card will further streamline how clients access medical care.
- Helps position public health insurance programs on the same level as private insurance programs.

5.31.3 Considerations

- System Design is important to ensure that using the swipe card is faster than using the interactive voice response system.
- Many providers may not have swipe card terminals so the issue of funding the terminals will need to be addressed. The system should be designed so that providers are not required to use a card reader and that rather they can access information via interactive voice response and securely via the Internet.
- May tend to push eligibility verification to the time of service rather than at scheduling. Verification at scheduling can help identify eligibility issues for the client prior to being seen in the provider's office for services and allows a period of time to deal with any eligibility issues.
- Will DSHS guarantee client eligibility for those providers that used the system to obtain an eligibility verification number for a specific date of service?
- Will DSHS require that authorization number to be submitted with the claim or will the authorization be stored in the system for automatic matching of incoming claims?

Note: A significant portion of the information in this recommendation was cited from the document titled 'E-Swipe Magnetic Card/Medicaid ID Card Replacement Strategy Draft' (see Appendix – References for additional information).

5.32 Change Long Term Care Vendor Updates to Daily

Currently, long term care vendor information is interfaced to ACES from the MMIS on a weekly basis. It is recommended that a daily interface be implemented. This is necessary because nursing home eligibility is dependent on a provider number that is obtained in that MMIS long-term care vendor file update. As a result, eligibility can be held up until the provider number is in ACES.

5.33 Create an interface between CARE and ACES

CARE is the system ADSA HCS social workers use to record functional eligibility determinations. In order to move ADSA programs currently paid through SSPS to MMIS, client participation data needs to be interfaced into ACES so it in turn can be interfaced MMIS for use in generating payments.

5.34 Process Select JRA Payments through MMIS

There are a number of JRA programs that are candidates for being paid through the new MMIS.

Medical and dental services for youth in medium and maximum-security institutions are state funded (not Medicaid eligible). Today those services are either paid to contracted providers or through the A-19 process. Most are A-19.

Contracted community facilities are candidates to be paid through the MMIS rather than A-19. These community facilities bill on a monthly per-bed basis. Some contracted facilities bill for guaranteed bed spaces whether filled or not.

BRS (Behavioral Rehab Services) tardy case management for youth on parole. These are match eligible earned dollars currently paid through Journal Vouchers (JV) and should be considered for payment through the new MMIS.

6. Appendix – Glossary

This Glossary includes the following items:

- Acronyms that appear in the text of this ACES Interface Assessment Report. Acronym initials are spelled out and accompanied by brief definitions.
- Terms that have a specialized meaning in the DSHS environment.
- Terms used to describe Department policies and data processing functions.
- Terms that appear in this deliverable that have a specialized meaning within the ACES Interface Assessment Report.

The Glossary is limited in scope to words and acronyms that appear in the ACES Interface Assessment Report. It is not intended to replace or supplant other glossaries used by DSHS.

Acronym initials appear in parentheses after the words they describe.

837: The HIPAA compliant Health Care Claims Transaction used by MAA for electronic claim submission.

1099: A federally mandated tax form sent annually to the IRS and to most providers that receive payments from DSHS. There are no deductions from payments to 1099 providers.

A-19: A claim form submitted to DSHS by providers of social services.

Access: To retrieve information for purposes of inquiry or update. See also **Electronic Access**.

Access to Baby and Child Dentistry (ABCD): A program that focuses on preventive and restorative dental care for Medicaid-eligible children from birth to age six, with parents encouraged to enroll children by age one.

Accounts Payable (AP or A/P): A record of the state's legal obligation to pay a vendor or provider.

Accounts Receivable (AR or A/R): A record of payments due to the state from providers, vendors, or clients.

Ad Hoc Report: A report generated on an as-needed basis (e.g., a legislative inquiry).

Adjust: To apply a debit or credit to an account or claim amount or to change.

Adult Family Home (AFH): A family home that contracts with DSHS to provide personal care and room and board for one to six adults unrelated to the person(s) providing the care. AFHs are licensed by ADSA.

Affiliated Computer Services (ACS): A large computer service firm that serves MAA as a claim processor and fiscal manager.

Agency Contracts Database (ACD): A database used to maintain contracts with providers. The MMIS Core Provider Agreements (CPAs) are not included in this database.

Agency Financial Reporting System (AFRS): The state financial system of record that includes general ledger, accounting, accounts payable and payments.

Aging & Disability Services Administration (ADSA): One of the seven administrations of DSHS. ADSA brings together long-term care programs, home care, residential care, boarding homes, adult family homes, and nursing homes that are targeted to elderly people and adults with disabilities.

Alert: A brief message or reminder that an online system displays to its users.

Algorithm: A rule or procedure for solving a particular problem.

Alien Emergency Medical (AEM): A program that pays for emergency medical services to non-citizens.

Ambulatory Payment Classification (APC): Categories of services and procedures developed for the facility component of ambulatory care. Included services are ambulatory surgery, emergency room and outpatient procedures, and services performed in ancillary clinic settings.

American Dental Association (ADA): A national organization that establishes standard codes for dental procedures.

American Sign Language (ASL): A complex visual-spatial language used by the deaf community in the United States and English-speaking parts of Canada. It is a linguistically complete, natural language and is the native language of many deaf men and women, as well as some hearing children born into deaf families.

American Society of Anesthesiologists (ASA): An organization of anesthesiologists that establishes anesthesia Procedure Codes that DSHS crosswalks to CPT Procedures.

Ancillary Health Services: Health services ordered but not performed by a physician, including but not limited to, laboratory services, radiology services, and physical therapy.

Applicant: An individual who has applied for assistance from DSHS but is not yet an eligible client.

Application Process: The process by which a DSHS applicant becomes a client, including filing and completion of an application form, in-person interviews, and verification of required information.

Apply: To put into operation or effect.

Assign: To designate or mark for a specific purpose.

Assistance Unit (AU): A group of people who apply for or receive assistance together for a program. A household receiving both TANF and Food Stamps will have two AUs, one for each program.

Associate: To bring together or to connect.

Audit: In claim processing, an automatic validation procedure that compares data on a claim with historical claim data, for example duplicate checking. Historical claim data can also be defined as information on another line on the same claim. Contrast with **Edit**.

Audit Trail: Supplementary information that enables a reviewer to identify each step of a process and its results.

Authorization: For medical services administered by MAA, the process by which a client or provider requests services that are not automatically included in medical benefits. For social services administered by other DSHS Administrations, the process by which a case manager or social worker approves services for a client.

Automated Client Eligibility System (ACES): A data processing system designed to support client, financial, and management activities within DSHS. Through this system, staff enter, update and inquire on data relating to assistance units, clients, other agencies, and providers. ACES maintains eligibility information for most DSHS programs and interfaces with MMIS.

Automatic/Automatically: Done by a computer without human intervention.

Automatic Maximum Allowable Cost (AMAC): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Automatic Voice Response System (AVRS or AVR): A telecommunications system that automatically responds to and records calls from interested parties.

BarCode: The computer system used by CSOs and others to track applications for benefits and perform application processing.

Batch Processing: A mode of computer processing in which data in submitted to a system and processed at a later time. Contrast with **On-line Processing**.

Beta Test: A second test of a computer system conducted by an entity other than the system developer.

Billing Provider: A provider of medical or medically related services or equipment that submits claims for the services or equipment. A billing provider can be the same as the performing or rendering provider or it can be a medical group or billing agent with a different name and identifier.

Buy-In: A premium paid by DSHS to the Social Security Administration on behalf of clients eligible for Medicare.

Callback: A feature of voice response systems in which the system automatically returns standard, pre-recorded messages to callers.

Call Management System (CMS): A telecommunications management system used to track incoming calls and to monitor the number of calls, length of calls, and hold times.

Capitation: Payments to health plans based on the number of covered individuals rather than on the services provided. Also called a "Premium." Contrast with **Fee-for-Service**.

Capture: To bring data into a system.

Case and Management Information System (CAMIS): An in-house mainframe system that tracks children's medical, dental, and EPSDT information for the Children's Administration.

Case Manager: A DSHS worker who is continuously responsible for assigned clients.

Case Management System: A computer system that enables case managers and social workers to manage client services and track client use of facilities and resources.

Certified Average Wholesale Price (CAWP): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Centers for Medicare & Medicaid Services (CMS): The federal Health and Human Services Agency (formerly called the Health Care Financing Administration or HCFA) that is responsible for Medicare and Medicaid Programs. CMS has historically maintained the UB-92 institutional EMC format specifications, the professional EMC NSF specifications, and specifications for various certifications and authorizations used by the Medicare and Medicaid programs. CMS is responsible for oversight of HIPAA administrative simplification transaction and code sets, health identifiers, and security standards. CMS

also maintains the HCPCS medical code set and the Medicare Remittance Advice Remark Codes administrative code set.

Chemical Dependency (CD): A general term to describe a physical or psychological reliance on drugs.

Children's Administration (CA): One of the seven Administrations' of DSHS. CA is committed to the safe and healthy growth and development of children in their homes, in out-of-home placements, and in day care. CA provides a comprehensive range of services to protect children from abuse and neglect, to support families, and to ensure quality care for children.

Children's Administration Management Information System (CASIS): A case management system that maintain data on CA clients.

Children's Health Insurance Program (CHIP): A program administered by MAA for the State of Washington. CHIP (also called the State Children's Health Insurance Program or SCHIP) is a program operated by the state, in partnership with the federal government under Title XXI of the Social Security Act. The federal government pays 66.28 percent of CHIP expenditures and the state pays 33.72 percent. Children from families with incomes up to 250 per cent of the Federal Poverty Level are eligible for CHIP. Children covered under CHIP receive their medical services from a managed care plan or from MAA's fee-for-service program. Families share in the costs of the program by paying monthly premiums and co-payments for some services.

Claim: A paper or electronic request for payment submitted by a fee-for-service provider.

Claim Form: A pre-printed sheet of paper on which a medical or medically related provider can enter identification and service information and submit for payment. The following claim forms are used by DSHS Administrations: HCFA- (or CMS-) 1500s for physician and practitioner services, UB-92s for inpatient and outpatient institutional services, ADA Forms for dental services. Pharmacy claims are normally submitted with on-line transactions. For non-medical social services, invoices sent by DSHS and returned by providers are equivalent to claims.

Claims Processing Assessment System (CPAS): An annual federal review of claim processing by State Medicaid Agencies.

Claims Processing Functions: Claim edits, audits, and pricing functions normally handled by an automated Claims Processing System.

Clean Claim: A claim that has no defect, impropriety (including a lack of any required substantiating documentation), or particular circumstance requiring special treatment that prevents timely payment.

Client: An eligible person in a program administered by DSHS. Also known as a recipient in the Medicaid environment.

Client Activity and Tracking System (CATS): A system used by the Juvenile Rehabilitation Administration to track juvenile placement, locations, and sentencing.

Client Management Information System (CMIS): An in-house DSHS system that tracks client contact information, including caller information and reasons for contact. CMIS subsystems track enrollments, complaints, recoupments, exemptions, and disenrollments. CMIS makes use of data extracted from MMIS and IPND.

Client on Review: A person receiving benefits who is being scrutinized by DSHS because the Agency has reason to believe that he or she is ineligible for services or is using services inappropriately.

Client Registry (CR): A case management tool designed to get case workers talking to each other. The tool is maintained by the Office of Research and Data Analysis.

CMS-64: A lengthy, federally mandated report (also known as the HCFA-64) produced by state Medicaid agencies such as MAA. CMS-64 data is the basis for the federal matching funds paid to Medicaid states.

CMS-1500: A standard claim form (also known as the HCFA-1500) for professional services.

Code Set: A group of standard values for a particular data element. Many code sets, including values of HCPCS Procedure Codes, are mandated by HIPAA.

Coinsurance: The portion of a fee-for-service provider's billed charges that Medicare or another non-Medicaid carrier pays for approved medical expenses.

Collection and Accounts Receivable (CARS): A system maintained by the Office of Financial Recovery for use in recovering overpayments.

Community Alternatives Program (CAP): A Medicaid waiver program that provides options in living arrangements to developmentally disabled clients in need of an Intermediate Care Facility - Mentally Retarded (IFC-MR) level of care.

Community Options Program Entry System (COPES): A Medicaid waiver program that provides a client who has been assessed as in need of nursing facility care the option to remain at home or in an alternate living arrangement.

Community Services Office (CSO): A local office of DSHS that provides cash, medical, and food benefits and services to eligible persons within a designated region.

Comprehensive Assessment Reporting and Evaluation (CARE): An in-house system that maintains information on client assessments and service authorizations for administrations other than MAA.

Computer Service Request (CSR): A request by system users for system changes or enhancements submitted on a standard form.

Conman: An in-house DSHS system that maintains contracted expenditures and other contract information.

Contact: An interchange between a DSHS worker and a client, provider, or other party. A contact can be in person, by phone, or by letter or e-mail.

Contact Management System: An automated system that tracks a customer's contacts with DSHS representatives.

Coordination of Benefits (COB): The process by which multiple health insurance carriers determine payments for covered services. Also known as Third Party Liability or TPL.

Co-Payment: The amount that a client pays towards the cost of a medical service. DSHS pays the remainder of the cost up to a set maximum rate.

Core Provider Agreement (CPA) Form: A standard form used to enroll an eligible provider in order to assign a unique provider identifier.

Correcting Coding Initiative (CCI) Edits: A large set of Procedure Code edits that prevent provider unbundling of Codes that are covered by a single comprehensive Code value.

Correspondence: Written communications with outside parties, frequently communications generated by computer systems.

Cost Avoidance: A form of COB in which a payer such as MAA refuses to pay a claim because another carrier is primary and refers the claim to the other carrier. Contrast with **Pay and Chase**.

County Designated Mental Health Professional (CDMHP): A professional who performs mental health assessments.

Create: To make or to produce or bring about by a course of action.

Critical Access Hospital (CAH): A program that was created by the 1997 federal Balanced Budget Act as a safety net device, to ensure that Medicare beneficiaries have access to health care services in rural areas. It allows flexible staffing options relative to community needs, simplifies billing methods and create incentives to develop local

integrated health delivery systems, including acute, primary, emergency, and long-term care.

Crosswalk: A list that associates one set of values with another, for example a crosswalk between J Procedure Codes and NDC Drug Codes.

Current Dental Terminology (CDT): A set of dental Procedure Codes created by the American Dental Association. CDT Codes appear within the HCPCS Procedure Code Set.

Current Procedural Terminology (CPT): A set of medical Procedure Codes performed by physicians and other practitioners. CPT Codes are also known as Level 1 HCPCS Codes.

Customer Automated Tracking System (CATS): An in-house system used by the Juvenile Rehabilitation Administration (JRA) that tracks provider and client enrollment and program participation.

Data: In a computer system, coded representations of meaningful words, numbers, or pictures. Contrast with **Process**.

Database Management System (DBMS): A sophisticated electronic file structure that optimizes the way in which a system's data is stored and accessed.

Data Warehouse: An integrated collection of computer-based information that is organized to answer strategic, rather than operational, questions.

Decision Support System (DSS): Software and databases designed to help people at all levels of an organization make decisions.

Define: To determine or identify the essential qualities of.

Denial: A determination that a client is not eligible for assistance or that information sufficient to establish eligibility is lacking.

Department of Health (DOH): A State of Washington department outside of DSHS that interfaces with DSHS Administrations in a variety of ways, including immunization registration, provider licensing, and vital statistics.

Department of Social and Health Services (DSHS): A State of Washington Department with seven administrations that provide medical and social services to 1.3 million children and families each year.

Derive: To deduce

Determine: To decide by choice of alternatives or possibilities.

Developmentally Disabled (DD): A category of severely handicapped clients.

Diagnosis Related Group (DRG): A set of codes that MAA uses to price inpatient claims for most Washington hospitals.

Disease Management Organization (DMO): An entity that oversees treatment protocols for patients with serious medical conditions.

Disease Management Program: An MAA program for voluntary case management of clients with serious medical conditions.

Division of Child Support (DCS): A division within ESA that establishes paternity and collects child support for public assistance and non-assistance clients. DCS also determines if a client is not cooperating with support collection activities.

Division of Developmental Disabilities (DDD): A division within ADSA that is responsible for services to developmentally disabled persons.

Division of Employment and Assistance Programs (DEAP): An ESA Division that coordinates services and payments for health screenings for refugees and GA applicants.

Division of Fraud Investigations (DFI): A division within the DSHS Management Services Administration responsible for detection and investigation of fraudulent activities by providers and clients.

Division of Medical Management (DMM): An MAA division that performs medical review and quality assurance.

Documentation: Written and/or graphic material that describes organizational procedures and/or system processes.

Doing Business As (DBA): A name assigned to businesses licensed by the State of Washington, including providers of medical and medically related services.

Drill down: The process of going from high-level information to lower-level information that supports it, for example, drilling down from a claim summary report to detail-level claim data.

Drill up: The process of summarizing lower-level, detailed information into high-level information, for example, drilling up from claims level data to create a claim summary report.

Division of Alcohol and Substance Abuse (DASA): The Division of Alcohol and Substance Abuse promotes strategies that support healthy lifestyles by preventing the misuse of alcohol, tobacco, and other drugs, and support recovery from the disease of chemical dependency.

Drug Enforcement Administration (DEA): The federal agency that assigns identification numbers to providers authorized to prescribe controlled drugs.

Drug Manufacturers: Corporations that manufacture prescription and over-the-counter drugs and provide rebates to State Medicaid Agencies for drugs on pharmacy claims.

Drug Rebate: A program in which State Medicaid Agencies apply to drug manufacturers for rebates for portions of payments that they have made for prescription drugs.

Drug Utilization Review (DUR): A feature of point-of-sale (POS) pharmacy claim systems that notifies pharmacists of the potential for adverse drug interactions and other situations in prescribed drugs may be contraindicated.

Durable Medical Equipment (DME): Reusable equipment, such as wheelchairs, required by some patients.

Durable Medical Equipment Region Carrier (DMERC): A Medicare carrier for durable medical equipment.

Early and Periodic Screening Diagnosis and Treatment (EPSDT): A federally sponsored program for childhood immunizations, checkups, screenings, and treatments (also called Healthy Kids in Washington State).

Eligibility A-Z (EA-Z) Manual: Designed for and used by Economic Services and Medical Assistance Administration staff. The manual provides administrative rules and procedures for staff to determine initial and ongoing eligibility for people applying for and receiving cash, food and medical assistance in Washington State.

Economic Impact Statement (EIS): A report describing the expected financial impact of a proposed activity.

Economic Services Administration (ESA): One of the seven administrations of DSHS. ESA provides economic support, employment training, child support, medical services, and other services to help people in need achieve and maintain self-sufficiency.

Edit: An automatic procedure that checks incoming data for completeness, validity, and consistency. In claim processing, edits are validation procedures that involve a single claim rather than historical claim data. Contrast with **Audit**.

Electronic Access: Access to data maintained by a computer system through a terminal, AVRS, IVRS, Web Site, swipe card, or other device.

Electronic Benefits Transfer (EBT): A method of transferring benefits by means of electronic transactions rather than paper checks or warrants.

Electronic Data Interchange (EDI): A method of transferring data.

Electronic Fund Transfer (EFT): A method of transferring funds by means of electronic transactions rather than paper checks or warrants. EFT payments from Medicaid Agencies to providers and health plans are supported by HIPAA Transactions.

Eligibility: Fulfillment of requirements and meeting of qualifications to receive medical and/or social services. ACES performs eligibility determination functions for most DSHS clients. Contrast with **Enrollment**.

Eligibility Verification System (EVS): An electronic system that tells requesting providers whether or not a person is eligible for benefits.

Eliminate: To remove entirely.

Emergency Room (ER): A section of a hospital for patients with serious injuries or medical conditions in need of immediate treatment.

Employer Identification Number (EIN): A federally assigned identification number similar to a Social Security Number but assigned to businesses and other employers rather than individuals.

Employment Security Department (ESD): A State of Washington Department outside of DSHS that MAA uses to obtain information on provider employees.

Encounter: A paper form or electronic transaction similar in format to a claim but used for reporting rather than to request payment. In the capitated Medicaid environment, health plans submit encounters to Medicaid Agencies such as MAA to report on member services. Contrast with **Claim**.

End State Renal Disease (ESRD): A serious kidney condition that frequently requires dialysis and other very costly treatments.

Enrollee: An individual eligible for medical benefits who participates in a particular program or health plan.

Enrollment: (1) The act of a client's becoming a member of a health plan, either by means of the client's decision or by an automatic process. (2) The act of a medical or medically related provider's applying for participation in the Medicaid Program on either a fee-for-service or capitated basis.

Ensure: To guarantee or make sure of an occurrence

EPIC: A national database of manufacturers' suggested retail prices.

Establish: To institute or bring into existence

Estimated Due Date (EDD): For a pregnant client, a physician's estimate of the date on which the baby will be delivered.

Exception Case Management (ECM): A unit within MAA that works with exceptional client situations such as health plan disenrollment requests and the Patients Requiring Regulation (PRR) program.

Exception to Rule (ETR): A category of authorizations for medical services that are not normally covered by MAA, for example breast reduction surgery for a woman with severe back problems.

Exception to Rule Database: A database used by MAA prior authorization staff to generate worksheets and client notification letters and to track program activity for ETR authorizations.

Executive Administration (EA): The Executive Offices of the DSHS Secretary and Deputy Secretary.

Expedited Prior Authorization (EPA): A method of authorization used by MAA that avoids manual review of authorization requests by analyzing previous authorizations to establish validity criteria for data on incoming claims.

Extended Database (EDB): An MMIS database of paid claims; used in extracting and reporting claims data rather than in claim adjudication.

Extensible Markup Language (XML): An Internet language that support transmission of formatted data.

Extract: To select and separate

Family Access to Medical Insurance Security (FAMIS): Enacted as XXI of the Social Security Act.

Federal Employment System: A system that maintains data on federal employees with which MAA interfaces for TPL information.

Federal Medical Assistance Percentage (FMAP): The percentage of state Medicaid expenditures contributed by the federal government. The percentage can differ for different kinds of Medicaid activities.

Federal Poverty Level (FPL): Guidelines developed and updated annually by the federal Department of Health and Human Services (HHS) that are used to establish eligibility criteria for many assistance programs. The FPL specifies income amounts for various household sizes below which people are considered impoverished.

Federal Upper Limit (FUL): Upper limits for drug payment amounts maintained by CMS.

Federally Qualified Health Center (FQHC): A community health center or clinic that provides services to low-income people and meets federal qualifications for receipt of Medicaid payments.

Federal Insurance Contributions Act (FICA): Social Security and Medicare deductions from employee income reported on W-2 Forms. Providers that receive 1099 Forms are responsible for their own FICA contributions.

Federal Unemployment Payroll Surtax (FUDA): Federal contributions to unemployment insurance funds that is deducted from employee income. Providers that receive 1099 Forms are responsible for their own FUDA contributions.

Fee-for-Service (FFS): Payment to providers based on services performed rather than on the number of clients covered. In Washington, the FFS program covers services to elderly and disabled Supplemental Security Income (SSI) clients, clients exempted from Healthy Options or in state administered programs, and Medicaid services not covered by managed care plans. Contrast with **Capitated**.

First Databank: An organization that maintains and distributes up-to-date electronic drug information on a monthly basis. The First Databank Database combines descriptive and pricing data with a selection of advanced clinical support modules.

FourThought Group (4TG): The company hired by DSHS to discover, analyze, and document the state's current and future Medicaid practices and system needs.

Fraud Abuse & Detection (FAD): A payment review and audit activity conducted by MAA's Information Services Division.

Frequently Asked Questions (FAQ): A common acronym for answers to questions posted on the Internet.

Full Time Equivalent (FTE): A widely used term for measuring the extent of an employer's employment. A full-time employee, or two half-time employees, is considered one FTE.

General Assistance (GA): A state-funded program that provides cash and medical benefits.

General Assistance-Unemployable (GA-U): A state-funded GA program that provides cash and medical benefits for persons who are physically and/or mentally incapacitated and unemployable for more than 90 days. GA-U medical care is limited.

Generic Code Number (GCN): A code assigned to a generic drug category.

Generic Sequence Number (GSN): Same as **Generic Code Number**.

Generate: To create or cause to be created.

GeoAccess: A third party vendor that processes and compiles provider data for the IPND.

Geographic Information System (GIS): A system of computer software, hardware and data used to manipulate, analyze and present information that is tied to a spatial location. Example: DSHS uses location data on providers and clients to analyze the relationship between the two, assess access and provide provider look up services by county, zip code, etc.

Graphic User Interface (GUI): A user interface to a computer system based on graphics (pictures and menus) rather than text. It uses a mouse as well as a keyboard as an input device.

Hardcopy: Paper rather than electronic representations of forms and information.

Health and Rehabilitative Services Administration (HRSA): This administration serves Washington citizens often characterized as those most profoundly in need. HRSA clients have needs arising from physical and mental disabilities, mental health problems, or chemical dependency.

Health Care Authority (HCA): A State of Washington entity that provides health insurance coverage to state employees and sponsors a Basic Health Plan for private sector employees with low incomes.

Health Care Financing Administration (HCFA): The former name for the Center for Medicare & Medicaid Services (CMS), the federal agency legislatively charged with administering the Medicare, Medicaid, and Children's Health Insurance Programs.

Health Care Financing Administration Common Procedure Coding System (HCPCS): The standard code set for Procedure Codes, including CPT Codes and codes for other medical and medically related services. This code set is still called HCPCS in spite of the federal agency's name change.

Health Plan Employer Data and Information Set (HEDIS): A set of federal report specifications created in the early nineties as part of President Clinton's health care initiative and originally intended for use by employers for comparing health plans available for their employees. HEDIS reports can also be used by Medicaid Agencies that contract with capitated health plans to compare service utilization by members of various plans.

Health Plan: An organization that maintains networks of medical providers and pays for medical services for enrolled clients in exchange for a prepaid monthly premium or capitation payment.

Healthy Options (HO): The DSHS Medicaid managed care program for low-income people in the State of Washington. Healthy Options offers eligible families, children under 19 including children in SCHIP, and pregnant women coverage for medical benefits.

Health Insurance Portability and Accountability Act (HIPAA): Federal legislation passed by Congress in 1996 that affects health care activities in a variety of ways. HIPAA Transaction and Code Set and Privacy and Security mandates are of most significance to DSHS.

Health Insurance Premium Payment (HIPP): A state program that pays the employee component of health insurance premiums for low wage workers.

HealthWatch Technologies (HWT): A health care systems company that provides payment accuracy auditing, overpayment recovery, and other services supported by claim data to MAA.

Health Level 7 (HL7): An international set of standard formats for passing health care data among computer systems. HL7 standards differ from the standards mandated by HIPAA Transactions and Code Sets in that they emphasize electronic messages about patients sent between providers rather than communications between providers and health care payers.

Home and Community Based Services (HCBS): A Medicaid waiver program that provides in-home and residential services for people who would otherwise be institutionalized.

Home and Community Based Waiver (HCBW): A directive issued by CMS that enables a State Medicaid Agency to sponsor non-institutional services for clients whose assessments would otherwise require institutional levels of care.

Home and Community Services (HCS): A division of Aging and Disablity Services Administration (ADSA).

Health Professions Quality Assurance (HPQA): A Washington Department of Health Office that licenses medical providers and investigates complaints from members of the public. HPQA maintains a Provider Licensing File that DSHS accesses to validate provider information at the time of enrollment.

HWT Database: A data warehouse with historical data from MMIS claims and SSPS invoices.

Identify: Select as matching a set of criteria.

Immigration and Naturalization Service (INS): The federal agency responsible for immigration procedures.

Infant Toddler Early Intervention Program (ITEIP): An ADSA early intervention program that provides services to children that schools recognize as developmentally disabled.

Information Services Division (ISD): The entity within MAA that administers and maintains computer systems.

Individual Taxpayer Identification Number (ITIN): An identifier assigned by SSA to individual taxpayers who are not eligible to receive a Social Security number.

Input: Data coming into a computer system by means of data entry, electronic transactions, or interface files. Contrast with **Output**.

Integrated Case Management System (ICMS): A system used by the Mental Health Division of DSHS to maintain information on clients.

Integrated Provider Network Database (IPND): A database that maintains information on providers in health plan networks including plans sponsored by MAA and HCA. It is the basis for provider data available from the DSHS Web Site.

Integration: Combining, associating, or bringing together. An integrated system is one in which all components operate consistently and in close association with one another.

Interactive Terminal Input System (ITIS): A client eligibility system formerly maintained by DSHS. ITIS data was converted to ACES in 1996.

Interactive Voice Response System (IVRS or IVR): An automated telecommunications system that provides callers with recorded instructions that enable them to request information and gives responses in English or another language.

Interfaces: Electronic files that are transferred from one computer system to another.

Interim Bill: An inpatient hospital claim that covers a partial rather than a complete stay.

International Classification of Diseases (ICD): The basic code set for medical diagnoses.

Internet: The worldwide network of computer networks that uses teleprocessing protocols to facilitate data transmission and exchange. The Internet is used throughout DSHS as a two-way information source.

InterQUAL: A set of automated decision support tools marketed by the McKesson Corporation.

Invoice Control Number (ICN): A number that identifies a claim including all of the service lines within it.

Involuntary Treatment Act (ITA): State of Washington legislation that permits involuntary commitment if, in the judgment of a county designated mental health professional, a person presents a danger to self, others, or property and/or the person is unable to provide for basic needs of safety and health.

J-Codes: HCPCS Procedure Codes for drugs dispensed by a physician rather than a pharmacist. The initial character of these codes is always "J".

Joint Application Development (JAD): A method of eliciting system requirements that features structured group processes and extensive documentation.

Juvenile Rehabilitation Administration (JRA): One of the seven Administrations' of DSHS. JRA provides preventative, rehabilitative, residential, and transitional programs for juvenile offenders.

KOVIS: A document scanning and retrieval system used by MAA to store Medicaid provider contracts.

Labor and Industries (L&I): The State of Washington Worker's Compensation Agency. It provides cash and medical benefits to eligible persons who are injured while working and interfaces with DSHS for provider employee information.

Length of Stay (LOS): The number of days that a person is in a hospital or residential facility.

Limited Liability Corporation (LLC): A type of business organization registered with the Washington Secretary of State.

Local Procedure Codes: Level 3 HCPCS Procedure Codes established by health care payers and formerly accepted by MAA on claims, especially claims for medical equipment and supplies. Local codes have been replaced by national HCPCS codes on HIPAA compliant claim transactions but are still used internally for claim adjudication within the current MMIS.

Lock-in: A program that restricts selected Medicaid clients to services from particular physicians and/or pharmacists.

Long-Term Care (LTC): A nursing facility in which people who are incapacitated because of age or disabilities reside.

Maintain: Keep in an unchanged status.

Manage: To direct or carry on business.

Management and Administrative Reporting Subsystem (MARS): A federally mandated MMIS subsystem that produces financial and utilization reports.

Management Services Administration (MSA): One of the seven Administrations' of DSHS. MSA provides centralized services and support to the public, vendors, Department staff, and facilities.

MAPPER: A client tracking system formerly used by JRA and replaced by CATS.

Maximum Allowable Cost (MAC): An amount on First Databank's Drug File that can be used in pharmacy claim pricing.

Medicaid: The medical assistance program described in Title XIX of the federal Social Security Act. Each state administers a separate Medicaid Program that is financed by both federal matching funds and state funds and is subject to federal review.

Medicaid Eligibility Verification System (MEVS): An interactive electronic system that medical providers use to verify eligibility for Medicaid clients.

Medicaid Management Information System (MMIS): A computer system mandated by CMS for all Medicaid state.

Medicaid Statistical Information System (MSIS): The system that produces the State MSIS Report that provides summary data on Medicaid eligibles, clients, and services, and on medical provider payments. Since 1972, all states and territories that operate Medicaid programs are required to report annually. The MSIS Report has 14 sections that contain aggregate data broken down by service types and demographic categories.

Medical Assistance Administration (MAA): One of the seven administrations of DSHS. MAA provides health care coverage to low-income families.

Medical Eligibility Determination Services (MEDS): A statewide CSO that determines children's eligibility in an expedited manner for applicants applying for Medicaid.

Medical Identification Card (MAID): MAID is generated by the ACES system monthly for client's eligible for medical assistance.

Medical Personal Care (MPC): A term for chore and personal care services paid by Medicaid.

Medically Needy (MN): An optional Medicaid program which usually requires the client to meet a "spenddown" liability.

Medicare: A federally sponsored health insurance program for people over 65 years old.

Medicare Carrier: A private company that contracts with Medicare to pay claims for Medicare beneficiaries.

Medicare Intermediary: A private company that contracts with Medicare to pay Medicare Part A claims for Medicare beneficiaries.

Medicare Enrollment Database (EDB): A national database of Medicare beneficiaries maintained by CMS.

Medicare Physician Fee Schedule Database (MPFSDB): A Medicare Data Base that is used by MAA as a basis for physician's payments.

Membership Billing Maintenance System (MBMS): A system operated by the Health Care Authority and accessed by MEDS for information on changes in eligibility.

Mental Health Division (MHD): A division within the DSHS Health & Rehabilitative Services Administration that is concerned with mental health services.

Modify: To make basic or fundamental changes

National Association of Boards of Pharmacy (NAPB): A national organization of state Boards of Pharmacy. State Boards of Pharmacy license pharmacists and support the interests of the pharmacy community.

National Association of Insurance Commissioners (NAIC): An organization of State Insurance Commissions that provides standards and guidelines for the insurance industry.

National Council for Prescription Drug Programs (NCPDP): An organization that maintains standard NDC Drug Codes and a standard, HIPAA compliant format for pharmacy claims.

National Drug Code (NDC): The standard code set for drugs obtained from pharmacies.

National Provider Identifier (NPI): A standard provider identifier to be mandated by HIPAA in conjunction with Provider Taxonomy Codes.

National Uniform Billing Committee (NUBC): An organization that develops and maintains paper and HIPAA compliant electronic standards for institutional claims.

Navigation: In an on-line computer system, the process of going from one computer screen to another.

Nursing Facility (NF): Same as **Long-Term Care Facility**.

Nursing Home (NH): Same as **Long-Term Care Facility**.

Office of Financial Recovery (OFR): The DSHS entity responsible for collection of debts owed to the Department, including financial, medical, and food stamp overpayments and Department liens.

Office of the Attorney General (OAG): The state entity responsible for criminal prosecution, including prosecution of fraudulent providers and clients.

OmniTrack: A computer system used by some MAA sections to track client contacts and by other sections to track provider contacts. It is a Sybase system operated by ACS.

On-line Processing: A mode of computer processing in which responses are immediate and interactive. Contrast with **Batch Processing**.

Optical Character Reader (OCR): An electronic device that reads handwritten characters created in a standard format and converts them to electronic data.

Outpatient Prospective Payment System (OPPS): A rule issued by CMS that specifies approximately 400 Ambulatory Payment Classifications (APCs) with relative weights and base payment rates for use in pricing medical and surgical services. APCs serve a role similar to that of DRGs for inpatient services.

Output: Data going from a computer system in the form or a file, electronic transaction, or report. Contrast with **Input**.

Patient Participation: The amount of individual financial assets that a client must spend down before the Medicaid program will make payment towards the cost of a medical service. Some states refer to this as a Cost Share.

Patient Requiring Regulation (PRR): A client in a lock-in program who is restricted to authorized providers.

Pay and Chase: A method of COB in which a payer pays claims that may have third party coverage and attempts to recover all or part of the payment amount from another insurance carrier. Contrast with **Cost Avoidance**.

Payment: In claims processing, the system component that generates checks or electronic transactions to transfer money to providers, health plans, and other external entities. Contrast with **Pricing**.

Payment Error Reduction and Measurement (PERM): A program that attempts to identify common claim errors by sampling and reviewing data from Claim History so that error rates can be reduced.

Payment Review Program (PRP): A State of Washington Program that performs post-payment review to identify claim errors that resulted in overpayments to providers and initiates recoveries.

Performing Provider Number: The provider identifier associated with the provider who renders care.

Personal Digital Assistant (PDA): A small, hand-held electronic device used to store information such as phone numbers and schedules.

Personal Identification Code (PIC): An "intelligent" Client Identifier used in the current Washington MMIS. It includes Client Name, Date of Birth, and other data elements that provide unique identification of each individual client.

Pharmacy Benefit Manager (PBM): An entity that processes pharmacy claims. ACS serves as a PBM for DSHS.

Point of Sale (POS) Pharmacy Claim System: A companion system to the MMIS currently operated by ACS in its role as PBM that processes claims for pharmacy benefits.

Portable Document Format (PDF): A widely used format for documents available on the Internet.

Premium: A payment made to an insurance carrier in return for coverage. In an MAA context, "premium" often refers to capitation payments made to health plans.

Price/Pricing: In claims processing, the determination of the amount that a provider should be paid for a particular covered service. Contrast with **Payment**.

Primary Care Provider (PCP): An individual physician, advanced registered nurse practitioner (ARNP), or physician assistant who provides and coordinates medical care services for managed care clients.

Primary Care Case Management (PCCM): An arrangement by which a provider contracts with DSHS as a primary care case management (PCCM) provider to provide health care services to eligible MAA clients under MAA's Managed Care Program.

Primary Care Options Program (PCOP): An MAA program that enables managed care clients to select primary care providers.

Prior Authorization (PA): A process by which clients or providers request MAA approval for certain medical services, equipment, drugs, and supplies, based on medical necessity. MAA approval for the services that require PA is a precondition for provider reimbursement. Expedited Prior Authorizations, Exception to the Rule Authorizations, and Limitation Extensions are forms of prior authorization used by MAA.

Privacy and Security: A HIPAA component that mandates confidentiality of personal medical information and secure maintenance of health care data.

Program of All-Inclusive Care for the Elderly (PACE): A Medicaid waiver program that provides home and community based services to Washington's frail and elderly population.

Procedure, Diagnosis, Drug, and DRG (PDDD) File: A basic Reference File in the current Washington MMIS.

Process: To execute a series of functions designed to achieve a specific result through to completion on a set of data in a computer system. Processes can involve comparison, arithmetic and logical operations, and decisions.

Produce: To make or cause to occur

Protected Population: Clients for whom a special level of confidentiality must be maintained due to their vulnerability or because of the requirements of federal or state legislation. Foster children, adopted children, abused women, JRA clients, and mental health clients are considered protected populations.

Provider: A person, organization, or institution that gives services to DSHS clients

Provider on Review: A provider of services contracted with DSHS who is subject to scrutiny because of suspected fraud, abuse, or inappropriate rendering of services.

Qualified Medicare Beneficiary (QMB): A program under which DSHS pays for Medicare deductibles and co-payments, Medicare Part B premiums, and/or Medicare Part C (which covers HMO premiums and co-payments) for clients who are eligible for both Medicaid and Part A Medicare.

Quality Assessment Improvement and Monitoring (Q-AIM): A section within MAA's Division of Medical Management that measures health care performance, conducts quality control and external quality review studies, monitors health care and service delivery systems, and is responsible for DMM contract development and execution.

Quality Assurance (QA): A process of analysis and review that endeavors to reduce errors and maintain quality for software, data, or procedures.

Query: An electronic request for information from the data maintained by a computer system.

Ratio Cost to Charge (RCC): A pricing methodology based on the relationship between the cost of a service and the amount charged for it.

Real Time: Data sharing or processing data functions with immediate and interactive response times.

Reconciliation: The process of comparing separate versions of the same data to ensure that both versions are identical. Client eligibility in MMIS, for example, could be reconciled with eligibility in ACES.

Regional Support Network (RSN): An entity that covers a county or a group of counties that is certified by the Mental Health Division (MHD) of DSHS to administer community mental health programs at a local level. Each RSN contracts with facilities and outpatient providers and distributes block grant funds for authorized mental health services.

Remittance Advice (RA): A paper document or electronic transaction that tells a provider how claims have been adjudicated. RAs are normally issued in association with claim payments.

Request for Proposal (RFP): A document issued by a government agency that solicits proposals for work by external entities. RFPs frequently involve development and/or maintenance of computer systems.

Residential Care Services (RCS): A division of ADSA that sets rules for and inspects residential care facilities.

Resource Based Relative Value Scale (RBRVS): A method of paying physicians for services that places a value on each procedure based on the duration, complexity, skill, and training required to perform the service. MAA multiplies RBRVS values by a statewide factor to determine physician payment rates.

Retain: To keep for a period of time.

Retention Duration: The length of time that a particular kind of data (for example, rate date) is maintained in a computer system.

Return on Investment (ROI): The amount of income or cost savings expected from an expenditure.

Revenue Code: A code set used on institutional claims and encounters to identity particular kinds of service.

Room and Board (R&B): The lodging and food services provided by a residential facility such as a hospice.

Rural Health Center (RHC): A clinic established by the 1977 Rural Health Clinic Act to stabilize access to outpatient primary care in underserved rural areas and encourage the use of physicians, physician assistants, nurse practitioners, and certified nurse midwives (CNMs).

S-Codes: Temporary national HCPCS Procedure Codes developed by Blue Cross/Blue Shield and other commercial payers.

Service Limit: A limitation placed by a health care payer on the extent or frequency of a medical service for which it will pay a provider.

Set (Noun): A group of one or more similar entities. (Verb): To apply a pre-determined value or attribute.

Social Security Administration (SSA): The federal agency that administers Social Security and SSI Programs.

Social Security Number (SSN): Identifiers assigned by SSA to employees and employment seekers. SSNs are used primarily to track Social Security contributions and benefits but are also widely used as individual identifiers for other purposes.

Social Service Payment System (SSPS): An automated system used by DSHS administrations outside of MAA to authorize and pay for social services.

Software: The electronic instructions that operate computers and related devices.

Special Commitment Center (SCC): The SCC is the civil commitment facility where violent convicted sex offenders can be sent for treatment by a court following completion of the offender's prison sentence.

Special Low-Income Medicare Beneficiary (SLMB): A Medicaid Program for clients who have applied for or are enrolled in Medicare Part A. Client income limits are over 100 percent but under 120 percent of the Federal Poverty Level. Under SLMB, DSHS pays only the client's Medicare Part B premium.

SSI-eligible clients: Persons who receive federal cash benefits under the SSA's Supplemental Security Income (SSI) Program and who automatically receive Categorically Needy (CN) medical coverage. The federal Social Security Administration (SSA) administers the SSI program. The SSI income standard is the Federal Benefit Rate (FBR).

State Administrated Child Welfare Information System (SACWIS): A case management, payment, and reporting system for foster parents, adoptive parents, and institutions that serve Child Welfare clients.

State Children's Health Insurance Program (SCHIP): Same as the Children's Health Insurance Program (CHIP).

State Data Exchange (SDX): The SDX is an exchange of information about a client's SSI status that is updated weekly.

State Maximum Allowable Cost (SMAC): A method of drug pricing that began in 1972 to help control the cost of the pharmacy program. The SMAC process identifies multi-source drugs (e.g., generic drugs) that have actual acquisition costs below established reimbursement rates to providers and adjusts reimbursement rates to make them closer to the actual acquisition costs.

Subset: To create set of elements from a given set.

Superior Court Management Information System (SCOMIS): A case management system used by Washington Superior Courts.

Supplemental Security Income (SSI): A federal program administered by SSA for severely disabled clients. MAA's FFS medical assistance program covers SSI clients.

Support: To perform an action that assists in the performance of another action, as in "support claim processing".

Surveillance and Utilization Review (SUR): A unit within MAA that performs post-payment review to detect fraud, abuse, and inappropriate utilization or provision of services.

Surveillance and Utilization Review Subsystem (SURS): A required MMIS subsystem that performs statistical analysis of claim data to identify providers and clients whose service and utilization patterns deviate from norms.

Telecommunications Device for the Deaf (TDD): An electronic device that converts telephone voice messages to written words that deaf people can read.

Temporary Assistance for Needy Families (TANF): A temporary welfare program called Work First in Washington. It was created by Welfare Reform legislation as a replacement for the Aid to Families with Dependent Children (AFDC) Program and gives aid to children and to the adults who care for them.

Therapeutic Consultation Service (TCS): An automated point-of-sale alert that facilitates appropriate and cost-effective use of prescription drugs.

Third Party Liability (TPL): Same as **Coordination of Benefits (COB)**.

Timing: The time frame in which a data processing activity is accomplished; on-line or batch.

Title XIX: The portion of the federal Social Security Act that covers Medicaid.

Title XXI: The portion of the federal Social Security Act that covers the Children's Health Insurance Program (CHIP).

Track: Maintain the identity and status of an entity as it is processed repeatedly by an automated or manual system.

Transaction Control Number (TCN): A unique field value that identifies a claim transaction assigned by Washington's MMIS.

Transactions and Code Sets (TCS): A HIPAA component that mandates formats for electronic transactions related to health care payment and specifies sets of data element values that are valid on transactions.

Transportation and Interpreter Services Section (TISS): An MAA Section that provides transportation and interpreter services to MAA clients. Transportation services are arranged through transportation brokers.

Transportation Brokers: Entities with which MAA contracts to arrange medical transportation services to Medicaid clients. Brokers screen client requests for eligibility and arrange the most appropriate and least costly method of transportation for clients, including public buses, gas vouchers, client and volunteer mileage reimbursements, nonprofit providers, taxies, "cabulances", and commercial buses and airlines.

Treatment and Assessment Report Generation Tool (TARGET): A system maintained by the DSHS Division of Alcohol and Substance Abuse (DASA) that maintains chemical dependency residential treatment data.

United States Post Office (USPS): An entity that, in addition to delivering mail, establishes standards for address components.

Universal Billing (UB): The basic claim form used for institutional services.

Universal Provider Identification Number (UPIN): The number used by Medicare to identify providers.

Update: To add, change, or delete the value of a field or set of fields.

Value: (Verb) To establishing a claim's payment amounts by using all appropriate methods of pricing.

W-2: The tax form that DSHS sends to individual employees and to the IRS. It shows FICA, FUDA, and other deductions from employee payments.

Washington Administrative Code (WAC): A set of rules governing the administration of federal and state laws and court decisions. Many DSHS policies and decisions reference particular WACs.

Washington Medical Integration Project (WMIP): A DSHS program developed to examine the potential benefits of providing services in a more integrated fashion to aged and disabled clients who receive medical care, mental health treatment, and long-term care services.

Working Connections Automated Program (WCAP): A client registry and case management system used by the WCCC Program.

Women, Infants & Children Program (WIC): A supplemental nutrition program for women, infants and children.

Worker's Compensation: Insurance that employers are required to have to cover employees who become sick or injured on the job.

Working Connections Child Care (WCCC): A DSHS program that helps families with children pay for child care to find jobs, keep their jobs, and get better jobs.

7. Appendix – References

The following references were used in the preparation of this report.

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ACES Interview with Chandra Moss – December 2003.

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DSHS Acronyms (From the Eligibility A-Z Manual)